

<b>Case Number:</b>	CM13-0037505		
<b>Date Assigned:</b>	12/13/2013	<b>Date of Injury:</b>	08/07/2007
<b>Decision Date:</b>	04/21/2014	<b>UR Denial Date:</b>	10/16/2013
<b>Priority:</b>	Standard	<b>Application Received:</b>	10/23/2013

### HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to an expert reviewer. He/she has no affiliation with the employer, employee, providers or the claims administrator. The expert reviewer is Board Certified in Physical Medicine & Rehabilitation, has a subspecialty in Interventional Spine and is licensed to practice in California. He/she has been in active clinical practice for more than five years and is currently working at least 24 hours a week in active practice. The expert reviewer was selected based on his/her clinical experience, education, background, and expertise in the same or similar specialties that evaluate and/or treat the medical condition and disputed items/services. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

### CLINICAL CASE SUMMARY

The expert reviewer developed the following clinical case summary based on a review of the case file, including all medical records:

This patient is a 53-year-old male with date of injury of 08/07/2007. The treatment recommendations were continuation of shoulder rehab. The patient was not interested in any further surgery. On the same report, there is a handwritten note, 10/11/2013, which states that the patient called the office ready to proceed with surgery. Report of MRI from 09/09/2013, right shoulder MR arthrogram reads undersurface partial thickness tear of the supraspinatus tendon at the level of the greater tuberosity. An operative report is from 10/08/2008 and this refers to arthroscopy, acromioplasty, and [REDACTED].

### IMR ISSUES, DECISIONS AND RATIONALES

The Final Determination was based on decisions for the disputed items/services set forth below:

#### **PURCHASE OF A COLD THERAPY UNIT FOR THE RIGHT SHOULDER:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG).

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation OFFICIAL DISABILITY GUIDELINES (ODG) ODGE GUIDELINES HAS THE FOLLOWING REGARDING CONTINUOUS-FLOW CRYOTHERAPY UNDER SHOULDER.

**Decision rationale:** This patient presents with chronic persistent shoulder pain being status post shoulder arthroscopic repair in 2008. An MRI from 09/09/2013 showed re-tear of the rotator cuff and the treating physician has recommended repeat surgery. The patient appeared to have been amenable to having repeat surgery. The request is for purchase of the cold therapy unit. MTUS Guidelines do not discuss cold therapy unit. However, ODG Guidelines supports the use of continuous flow cold therapy for postoperative care and for 7 days only. Recommendation is for denial of the purchase of cold therapy unit for the right shoulder.